ASAIS ID: _____ Last Name: _____ First Name: _____ MI: _____

AL DMH/MR SASD Adolescent Placement Assessment

DIMENSION 1. ACUTE INTOXICATION AND / OR WITHDRAWAL POTENTIAL

Do you have a history of withdrawal symptoms? ☐ Yes ☐ No

When you haven't been able to obtain alcohol and/or other drugs (AOD), cut down on your use, or stopped using; have you experienced any of the following:

☐ Diarrhea ☐ Seizures ☐ Fever ☐ Agitated (fidget, pace, etc.)
☐ Hand Tremors ☐ Nausea / Vomiting ☐ Sweating or heart racing ☐ Yawning
☐ Fatigue ☐ Insomnia or Hypersomnia ☐ Anxiety ☐ Muscle aches
☐ Vivid, unpleasant dreams ☐ Memory Loss ☐ Increased appetite ☐ Move and talk slower than usual
☐ See, feel, or hear things that aren't there ☐ Feeling sad, tense, or angry ☐ Runny nose / watery eyes

Are you currently experiencing any of the above? ☐ Yes ☐ No Explain: _____

Have any of these symptoms kept you from participating in social, family, school or other activities? ☐ Yes ☐ No

Have you used AOD to stop or avoid having these symptoms? ☐ Yes ☐ No

Are the symptoms due to a medical condition or some other problem? ☐ Yes ☐ No

Substance Use Background Please use the following codes on the tables below:
Route of Administration:

1- Oral 2 - Smoking 3 - Inhalation 4 - Injection-IV 5 - Injection-Intramuscular 8 - Other (Specify) _____

Note: #4 indicates the client is a priority population

Frequency of Use: 1 – No use in the past month 2 – 1-3 times in the past month 3 -1-2 times in the past week

4 – 3-6 times in the past week 5 - Daily 8 - Other

	Class of Substance	Specific Substance	Route of Admin.	Age First Used	Last Use	How Long Used	Frequency of Use	Periods of Abstinence	Rank Substance in order of use
A	None								
B	Alcohol								
C	Cocaine/Crack								
D	Marijuana								
E	Heroin								
F	Non-Prescription Methadone								
G	Other Opiates and Synthetics								
H	PCP								
I	Other Hallucinogens								
J	Methamphetamine								
K	Other Amphetamines								
L	Other Stimulants								
M	Benzodiazepines								
N	Other Nonbenzodiazepine tranquilizers								
O	Barbiturates								
P	Other non-barbiturate sedatives or hypnotics								
Q	Inhalants								
R	Over-the-counter								
Y	Other								
U	Unknown								

DIMENSION 2. BIOMEDICAL CONDITIONS AND COMPLICATIONS

Do you have / have you had any medical problems, including infectious communicable diseases? ☐ Yes ☐ No

Do you have any known allergies? ☐ Yes ☐ No Explain: _____

Does your chemical use affect your medical conditions in any way? ☐ Yes ☐ No _____

List any medications you currently take, have taken, or should take:

Medication	Prescribed For	Dosage	Frequency	Taking as Prescribed	
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No

List previous hospitalizations:

Date	Facility	Length of Stay	Treated For

Are you pregnant? ☐ Yes ☐ No Are you receiving prenatal care? ☐ Yes ☐ No # of Pregnancies _____

TB Checklist Have you had TB or tested positive for TB in the past? ☐ Yes ☐ No

For more than ***two weeks*** do you….

Have sputum-producing cough?	☐ Yes ☐ No	Have night sweats?	☐ Yes ☐ No
Cough up blood	☐ Yes ☐ No	Have a fever	☐ Yes ☐ No
Have loss of appetite	☐ Yes ☐ No	Receive a TB medication	☐ Yes ☐ No

DIMENSION 3. EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS AND COMPLICATIONS

As a child, were there any serious physical injuries or mental illnesses causing trauma? ☐Yes ☐ No

Describe: _____

Have you ever been diagnosed with a Mental Illness? ☐ Yes ☐ No Describe: _____

Have you ever had any treatment for mental/emotional problems? ☐ Yes ☐ No If yes,

When	Where	Level of Care	Length of Tx	Treated For

Have you ever been the victim or perpetrator of abuse: ☐ Sexual ☐ Domestic Violence ☐ Physical ☐ Emotional ☐ Neglect

When: _____ By Whom: _____

Did you receive intervention: ☐ Yes ☐ No Further Assessment Needed: ☐ Yes ☐ No

In the last year, have you felt like hurting or killing yourself? (suicidal ideation) ☐ Yes ☐ No Describe: _____

In the last year, have you felt like hurting or killing someone else? (homicidal ideation) ☐ Yes ☐ No Describe: _____

In the last year, have you experienced hallucinations or difficulty telling what is real from that which is not? (auditory, visual, olfactory, tactile) ☐ Yes ☐ No Describe: _____

In the last year, have you had trouble remembering, concentrating or following simple instructions? ☐ Yes ☐ No Describe: _____

Mental Status Examination

While prompts are provided below, the assessor should make sure to describe his/her observations and impressions of the person for each grouping below.

ORIENTATION

(capacity to identify and recall one's identity and place in time and space; ask directed questions)

Orientation:	☐ Normal	☐ Deficits:	☐ Person	☐ Place	☐ Time	☐ Situation

GENERAL APPEARANCE

(Include general observations about the person's appearance and expression)

Dress:	☐ Appropriate	☐ Meticulous	☐ Eccentric	☐ Seductive	☐ Disheveled
Grooming:	☐ Appropriate	☐ Meticulous	☐ Dirty	☐ Poor	☐ Bizarre
Facial Expression:	☐ Appropriate	☐ Flat	☐ Sad	☐ Angry	☐ Fearful

MOOD/AFFECT

(Mood: sustained emotional state; emotional tone the client subjectively feels i.e. what the client says / Affect: outward expression of person's current feeling state, how they appear to you i.e. facial expressions, body language, laughter, use of humor, tearfulness)

Mood:	☐ Depressed	☐ Euphoric	☐ Anxious	☐ Irritable	☐ Euthymic (normal)
Affect:	☐ Hostile	☐ Blunted	☐ Labile	☐ Broad	☐ Flat

SELF-CONCEPT

Self-concept:	☐ Self-assured	☐ Realistic	☐ Low self-esteem	☐ Inflated self-esteem

SPEECH

(comment on tone, volume and quantity)

Speech:	☐ Normal	☐ Pressured	☐ Stammering	☐ Foreign
	☐ Soft	☐ Rambling	☐ Slurred	☐ Mute
	☐ Loud	☐ Echolalia (compulsive repletion of word)		

MEMORY

(could explain recent and past events in their history; recalls three words immediately after rehearsal then five minutes later; recalls your name after 30 minutes)

Immediate:	☐ Intact	☐ Mildly Impaired	☐ Moderately Impaired	☐ Severely Impaired
Recent:	☐ Intact	☐ Mildly Impaired	☐ Moderately Impaired	☐ Severely Impaired
Remote:	☐ Intact	☐ Mildly Impaired	☐ Moderately Impaired	☐ Severely Impaired

THOUGHT PROCESS

(the movement of thought, the dynamics of how one thought connects to the next; observe speech, some behavior; may need a few targeted questions)

Thought Process:	☐ Logical	☐ Relevant	☐ Coherent	☐ Goal Directed	☐ Illogical
	☐ Incoherent	☐ Circumstantial	☐ Rambling	☐ Flight of Ideas	
	☐ Loose Associations	☐ Tangential	☐ Grossly Disorganized	☐ Blocking	
	☐ Neologisms	☐ Clanging	☐ Confused	☐ Perplexed	☐ Confabulating

THOUGHT CONTENT

(A description of the topics one is thinking about)

Thought Content:	☐ Normal	☐ Somatic Complaints	☐ Illogical Thinking	☐ Hopelessness	☐ Suspicious
	☐ Guilt	☐ Obsessions/Compulsions	☐ Phobias	☐ Poverty of Content	
	☐ Suicidal or Homicidal Ideation	☐ Prejudices/Biases	☐ Hypochondriac	☐ Depressive	

JUDGMENT AND INSIGHT

(Judgment: ability to make wise decisions, especially in everyday activities and social matters; Insight: awareness of problems, what they are, and their implications)

Judgment:	☐ Good	☐ Partial	☐ Limited	☐ Poor
Insight:	☐ Good	☐ Partial	☐ Limited	☐ Poor

Notes: _____

DIMENSION 4. READINESS TO CHANGE

Do you have any behaviors that you need to change? (e.g. criminal activity, fighting, cursing) ☐ Yes ☐ No Describe: _____

Do you think you have a problem with AOD and/or mental health? ☐ Yes ☐ No Please explain your response below:

Have you tried to hide your AOD use? ☐ Yes ☐ No Has anyone ever complained about your AOD use? ☐ Yes ☐ No

Has your AOD use caused you to feel depressed, nervous, suspicious, decreased sexual desire, diminished your interest in normal activities or cause other psychological problems? ☐ Yes ☐ No

Has your AOD use affected your health by causing numbness, blackouts, shakes, tingling, TB, STD's, or any other health problems? ☐ Yes ☐ No

Have you continued to use despite the negative consequences (at work, school, or home) of your use? ☐ Yes ☐ No

Have you continued to use despite placing yourself and others in dangerous or unsafe situations? ☐ Yes ☐ No

Have you had problems with the law because of your use? ☐ Yes ☐ No

Has your AOD use affected you socially (fights, problem relationships, etc.)? ☐ Yes ☐ No

Do you need more AOD to get the same high? ☐ Yes ☐ No

Do you spend a great deal of time in activities to obtain AOD and / or feeling it's affects? ☐ Yes ☐ No

Has your AOD use caused you to give up or not participate in social, occupational or recreational activities that you once enjoyed? ☐ Yes ☐ No

Have you continued to use after knowing it caused or contributed to physical and psychological problems? ☐ Yes ☐ No

Have you used larger amounts of AOD than you intended? ☐ Yes ☐ No

Indicate the ***URICA*** score & stage of readiness:

Alcohol Use: _____ ☐ Pre contemplation ☐ Contemplation ☐ Preparation (Action) ☐ Maintenance

Drug Use: _____ ☐ Pre contemplation ☐ Contemplation ☐ Preparation (Action) ☐ Maintenance

DIMENSION 5. RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL

How many times have you been treated for *Alcohol or Drug Problems*?

Date	Facility	Length of Stay	Treated For	Type of Discharge

Have you had any periods of abstinence from AOD and / or periods with no mental health problems? ☐ Yes ☐ No

If yes, please describe: _____

How was that abstinence maintenance /achieved? _____

What would you consider your relapse triggers? _____

Are you aware of what caused you to relapse? _____

ASAIS ID: _____ Last Name: _____ First Name: _____ MI: _____

Are you participating in any support groups? (AA, CA, NA, church, other) ☐ Yes ☐ No Do you have a sponsor? ☐ Yes ☐ No

Explain: _____

Have you ever participated in: ☐ AA ☐ NA ☐ CA ☐ Support Group ☐ Had a Sponsor

In the past year, have you tried to reduce the effect of the current issues/problems? _____

DIMENSION 6. RECOVERY / LIVING ENVIRONMENT

Living Arrangement: _____ **years** _____ **months** **Number in Household:** _____

A ☐ Independent Living
B ☐ Resides with Family
C ☐ Homeless / Shelter
D ☐ Jail / Correctional Facility
E ☐ Other Institutional Setting (nursing home, etc)
F ☐ Center Operated / Contracted Residential Program
G ☐ Center Subsidized Housing
H ☐ Alabama Housing Finance Authority Housing
I ☐ Other: _____

Employment Status: A ☐ Full-time B ☐ Part-time C ☐ Unemployed, looking D ☐ Homemaker
E ☐ Student F ☐ Retired G ☐ Disabled
H ☐ Confined to Institution/Correction Facility I ☐ Unemployed, not looking for 30 days S ☐ Supported employment

Employment History:

Employer	Position	Dates Employed	Reason for Leaving

Education

Are you currently in school, enrolled in a GED program, or a vocational program? ☐ Yes ☐ No Grade Level
If yes, where?

Legal Status ☐ Voluntary ☐ Involuntary, Criminal ☐ Not Guilty by Reason of Insanity

Detailed Legal Status
☐ None ☐ State /Federal Court ☐ Formal Adjudication ☐ Probation/Parole ☐ Other Legal Situations
☐ Diversionary Program ☐ Prison ☐ DUI / DWI ☐ Other: _____

Arrest History

	# of Arrests:	Convicted:			# of Arrests:	Convicted:	
Assault		☐ Yes	☐ No	Public Intoxication		☐ Yes	☐ No
Auto Theft		☐ Yes	☐ No	Rape		☐ Yes	☐ No
Burglary		☐ Yes	☐ No	Receiving Stolen Property		☐ Yes	☐ No
CHINS		☐ Yes	☐ No	Robbery		☐ Yes	☐ No
Criminal Trespass		☐ Yes	☐ No	Shoplifting		☐ Yes	☐ No
Distribution		☐ Yes	☐ No	Theft of Property		☐ Yes	☐ No
DUI		☐ Yes	☐ No	Violation of Probation		☐ Yes	☐ No
Harassment		☐ Yes	☐ No	Domestic Violence		☐ Yes	☐ No
Minor in Possession		☐ Yes	☐ No	Child / Elder Abuse		☐ Yes	☐ No
Possession		☐ Yes	☐ No	Other		☐ Yes	☐ No

# of Arrests in 30 days Prior to Admission _____ Probation Officer: _____

Explanation of the above to include outcome: _____

Social/Recreational

What type of social activities do you and your peers participate in? _____

What type of social activities did you participate in prior to your alcohol/drug use? _____

List and describe any support groups, organizations, clubs that will help you in your recovery efforts? _____

How often do you participate in these activities? _____

Do you have any hobbies or leisure activities you'd like to learn?

What do others consider to be your strengths (including interests, talents, skills and abilities, knowledge/education, religion/spirituality, culture/community, school, work, etc.)?

Family

Do you have dependent children? ☐ Yes ☐ No Ages: _____

Note: A Yes response for females indicates the client is a priority population

Who has custody of these children? _____

Is there childcare available for these children? ☐ Yes ☐ No Describe: _____

Do you feel you have adequate parenting skills? ☐ Yes ☐ No Would you be interested in receiving more skills? ☐ Yes ☐ No

Family History of Mental Retardation: ☐ Yes ☐ No Describe: _____

Quality of interaction with family: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Level of satisfaction with support system: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Describe your relationship with your:

Mother: _____

Father: _____

Siblings: _____

Other Caretakers: _____

Children: _____

Is your current living environment drug and alcohol free? ☐ Yes ☐ No Explain: _____

Who would you ask to take you to the hospital if you were to suddenly become ill? _____

Would you call the same person to tell some really good news? If not, why and who would you call? _____

ASAM PPC-2R Diagnostic Summary (summarize each dimension as assessed):

Risk Rating: 0 = Indicates full functioning; no severity; no risk in this Dimension. (NOTE: A higher number indicates a greater level of severity)

Risk Rating: 1-4 = Indicates various levels of functioning and severity and the level of risk in this Dimension.

Source: ASAM PPC-2R, pgs 281-312

Dimension 1: Acute Intoxication and / or withdrawal potential: _____

Risk Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Dimension 2: Biomedical conditions and complications: _____

Risk Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Dimension 3: Emotional / Behavioral / Cognitive Conditions and Complications:

Risk Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Dimension 4: Readiness to Change:

Risk Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Dimension 5: Relapse / Continued Use or Continued Problem Potential:

Risk Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Dimension 6: Recovery / Living Environment:

Risk Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

CLIENT CHARACTERISTIC DATA SUMMARY

ASAIS ID: _____ Date of Birth: ☐

Last Name: _____ First Name: _____ MI: _____

Co Dependent/Collateral: ☐ Yes ☐ No Principal Source of Referral: ☐ ☐

Client Transaction Type: ☐ Admission ☐ Transfer/Change in Service Fund Code: ☐ SA ☐ OR

Problem Substances

	Type	Detail	Route	Frequency	Age of First Use
Primary					
Secondary					
Tertiary					

Employment Status: ☐ Hearing Status: ☐ Linguistic Status: ☐

Living Arrangements: ☐ Pregnant at Time of Admission: ☐ N/A ☐ Yes ☐ No Veteran: ☐ Yes ☐ No

Co-Occurring Disorders Screen: ☐ Negative ☐ Positive Co-Occurring Disorders Assessment: ☐ Yes ☐ No

Co-Occurring: ☐ Yes ☐ No ☐ Unknown Opioid Maintenance Therapy: ☐ Yes ☐ No ☐ Unknown

Number of Prior Treatment Episodes: ☐ ☐ Number of Arrests in 30 days Prior to Admission: ☐ ☐

Financial Support: ☐ ☐ ☐ Health Insurance: ☐ ☐ Source of Payment: ☐ ☐

DSM-IV Diagnosis

Code: Description:

Axis I

Primary _____ _____

_____ _____

Secondary _____ _____

Axis II

_____ _____

_____ _____

Axis III _____

Axis IV

☐ None
1 ☐ Problems with primary support group
2 ☐ Problems related to social environment
3 ☐ Educational Problems
4 ☐ Occupational Problems
5 ☐ Housing Problems
6 ☐ Economic Problems
7 ☐ Problems with access to health care services
8 ☐ Problems related to interaction with legal system / crime
9 ☐ Other psychological and environmental problems

Axis V Current GAF: _____

Population Codes:

☐ A – Alcohol/Drug Using Adols.
☐ V - Women IV Drug User
☐ I – Male IV Drug Users
☐ P – Preg. Women/Women w/dep. Child. IV drug users
☐ F – Preg. Women/Women w/dep. child. alcohol or drug using
☐ D – Adols. IV Drug Users
☐ W – Alcohol/Drug Using Women
☐ N – Not Applicable or Alcohol / Drug Using Males

LEVEL OF CARE PLACEMENT SUMMARY

Assessed Level of Care: (Check one, unless also receiving OMT)

A ☐ Level 0.5 - Early Intervention
B ☐ Level I - Outpatient
C ☐ Level II.1 – Intensive Outpatient
D ☐ Level II.5 – Partial Hospitalization
E ☐ Level III.I – Clinically Managed Low Intensity Residential Services
F ☐ Level III.3 - Clinically Managed Medium Intensity Residential Services
G ☐ Level III.5 - Clinically Managed High Intensity Residential Services
H ☐ Level III.7 – Medically Monitored Intensive Inpatient Treatment
I ☐ Level IV - Medically Managed Intensive Inpatient Treatment
J ☐ Level I-D - Ambulatory Detoxification without Extended On-Site Monitoring
K ☐ Level II-D - Ambulatory Detoxification with Extended On-Site Monitoring
L ☐ Level III.2-D - Clinically Managed Residential Detoxification
M ☐ Level III.7-D – Medically Monitored Inpatient Detoxification
N ☐ Level IV-D – Medically Managed Intensive Inpatient Detoxification
O ☐ Opioid Maintenance Therapy

Placed Level of Care: _____

Reason for Difference:

1 ☐ N/A No Difference
2 ☐ Service not available
3 ☐ Indicated level denied by supervisor
4 ☐ Screener override
5 ☐ Consumer preference
6 ☐ Court Order
7 ☐ Waiting List
8 ☐ Funding problem
9 ☐ Transportation or Logistical problem
10 ☐ Other

Disposition:

1 ☐ Admitted to: _____ for assessed level of care **Date of Admission:** _____

2 ☐ Referred to _____ for assessed level of care

3 ☐ Assessed level not available, referred to _____ for interim care

4 ☐ No services available, referred to _____ , _____ ,

_____ and placed on waiting list(s) in ASAIS

5 ☐ Refused further services. Client discharged.

Release of Information: ☐ An appropriate release for this information is on file for this client

Indigent Offender:	☐ Yes ☐ No	Special Women's Program:	☐ Yes ☐ No
Special Adolescent Program:	☐ Yes ☐ No	Pardons and Paroles Program:	☐ Yes ☐ No
HIV Early Intervention Program:	☐ Yes ☐ No	Special COD Program:	☐ Yes ☐ No

Medical provider review of LOC Assessment:

_____ Agree with the diagnostic impression
_____ Agree with the level of care determination
_____ Agree with the recommended admission to level of care
_____ Agree with the preliminary treatment plan
_____ Treatment authorization _____ Number of days / hours approved
_____ Recommended additional services _____
_____ Need additional information _____

_____ Client Signature _____ Date

_____ Staff Signature and Credentials _____ Date

_____ Staff Signature and Credentials _____ Date

_____ Physician Signature _____ Date